HEALTHY FAMILIES STATEMENT OF ANNUAL INCOME

Patient Name: _____ Date of Birth: _____

CIN#:_____ CCS#: _____

My family's annual household income is: (Refer to your California Tax Return)

[ ] Adjusted Gross Income – Line 14 on form 540A $_____

[ ] Adjusted Gross Income – Line 17 on form 540 $_____

[ ] I did not file taxes last year. My gross monthly income is $_____

I declare that the foregoing answer is true and correct to the best of my knowledge.

[ ] Signature of Applicant/Parent/Legal Guardian Date Signed

_____ _____

Or,

[ ] Certified Telephonically/Signature of County Staff Date Signed

_____ _____

This information is only being used to confirm your child's eligibility for the CCS program and will not effect the payment of services to treat your child's CCS eligible medical condition that have been authorized by CCS.